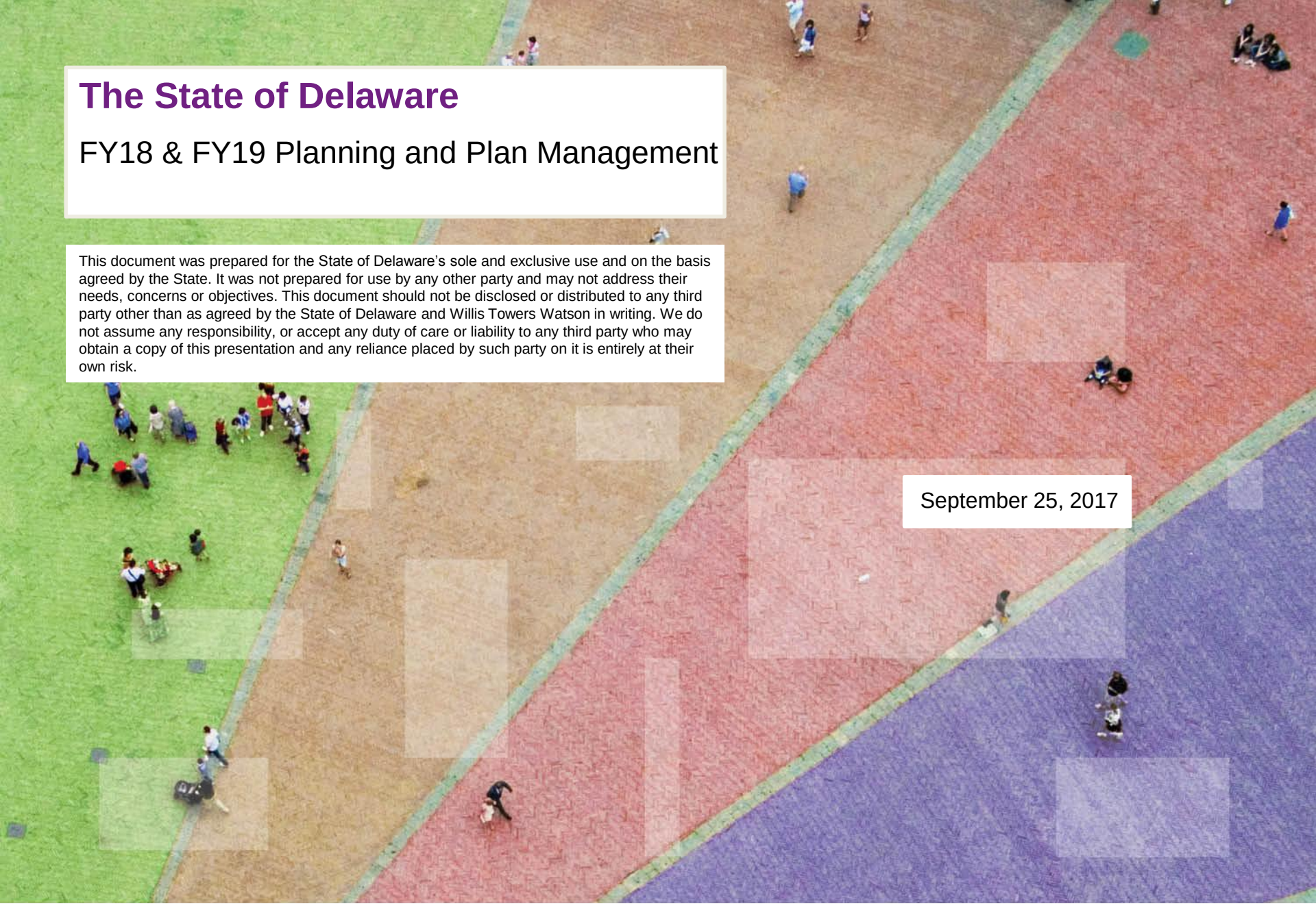


The State of Delaware

FY18 & FY19 Planning and Plan Management

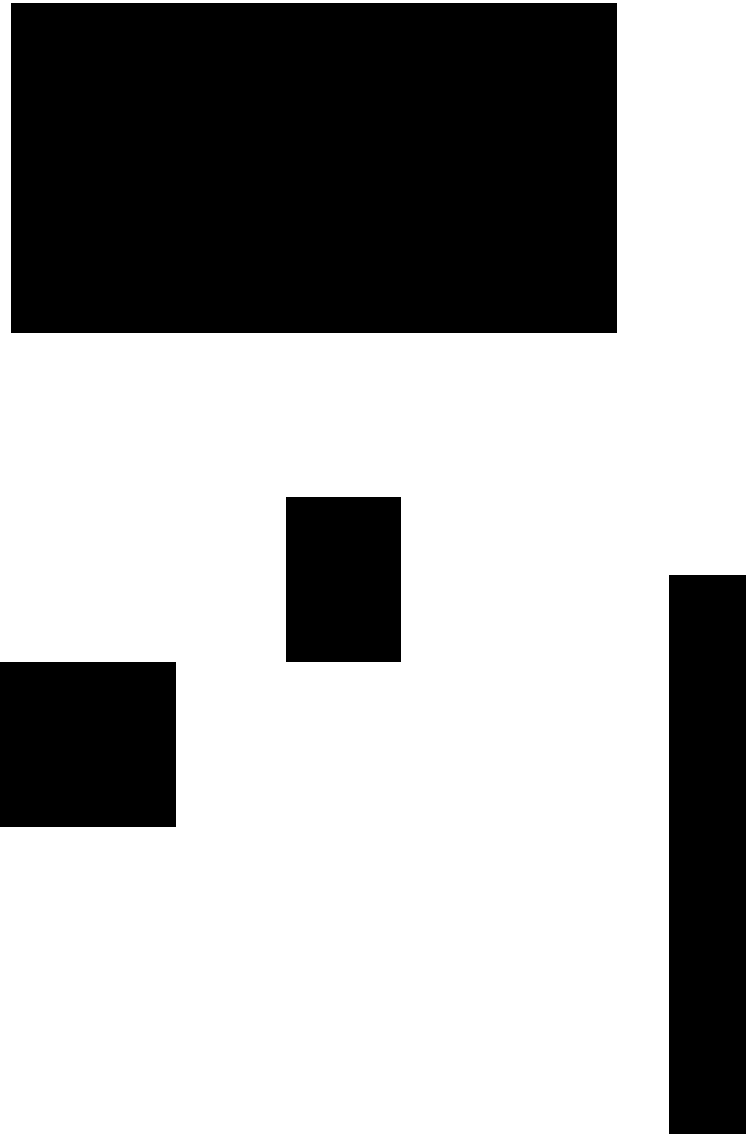
September 25, 2017

Willis Towers Watson

Contents

- Reframing the Long Term Plan
- Long Term Health Care Cost Projections for GHIP
- FY18/FY19 Planning *(follow-ups from 8/21 SEBC meeting)*
- Next Steps

Reframing The Long Term Plan



Multi-year framework

- During the summer of 2016, the SEBC created a multi-year strategic framework aimed at tackling several goals for the GHIP[1]
- Items were organized as potential considerations to attain the stated goals
- Highlighted below are broader categories for which the recent topics were derived for SEBC consideration (Centers of Excellence, Site-of-Care Steerage, etc.)
- This framework will continue to be utilized as a tool to provide guidance for the SEBC, and will be modified to the extent new ideas or approaches are to be considered

Approved and Voted on by SEBC, December 2016

Goal	To prepare for 2018 and beyond (7/1/16 – 6/30/2017)	To prepare for 2019 and beyond (7/1/17 – 6/30/2018)	To prepare for 2020 and beyond (7/1/18 – 6/30/2019)
Addition of at least 1 value-based care delivery (VBCD) model by end of FY2018	★ Evaluate local provider capabilities to deliver VBCD models via medical third party administrator (TPA) RFP • State-sponsored Health Clinic Request for Information (RFI) ★ Implementation of VBCD models from RFP (including COEs) • Evaluation of clinical data to implement more value-based chronic disease programs ★ Promote medical plan TPAs' provider cost/quality transparency tools	★ Implementation of VBCD models from RFP (including COEs) • Look for leveraging opportunities with the DCHI and DHIN to partner on promotion of value based networks (including APCD initiative) • Identify opportunities to partner and encourage participation in VBCD models using outside vendors, TPAs and DelaWELL • Educate GHIP population on other provider quality tools from CMS, Health Grades, Leapfrog, etc.	• Continue to monitor and evaluate VBCD opportunities
Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020	★ Negotiate strong financial performance guarantees ★ Select vendor(s) with most favorable provider contracting arrangements ★ Select vendor(s) that can best manage utilization and population health ★ Evaluate bidder capabilities surrounding Centers of Excellence via medical TPA RFP • Educate GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) ★ Evaluate vendor capabilities surrounding UM/DM/CM* via medical TPA RFP • Evaluate feasibility of reducing plan options and/or replacing copays with coinsurance* • Educate GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) • Evaluate incentive opportunities through incentive-based activities and/or challenges • Change certain plan inequities, e.g., double state share and Medicfill subsidy*	★ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM* and other medical and Rx UM programs, where necessary • Explore avenues for building "culture of health" statewide • Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) • Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) • Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*	★ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM* and other medical and Rx UM programs, where necessary • Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) • Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) • Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*
GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020	• Launch healthcare consumerism website • Roll out and promote SBO consumerism class to GHIP participants ★ Evaluate recommendations for creative ways to drive engagement and participation in consumer driven health plans via medical TPA RFP through leveraging vendor tools and technologies	• Offer a medical plan selection decision support tool (e.g., Truven's "My Benefits Mentor" tool) ★ Promote cost transparency tools available through medical TPA(s) • Evaluate feasibility of offering incentives for engaging in wellness activities	• Change medical plan designs and employee/retiree contributions to further differentiate plan options* • Change the number of medical plans offered*

*May require changes to the Delaware Code

★ Denotes activity through TPA RFP process

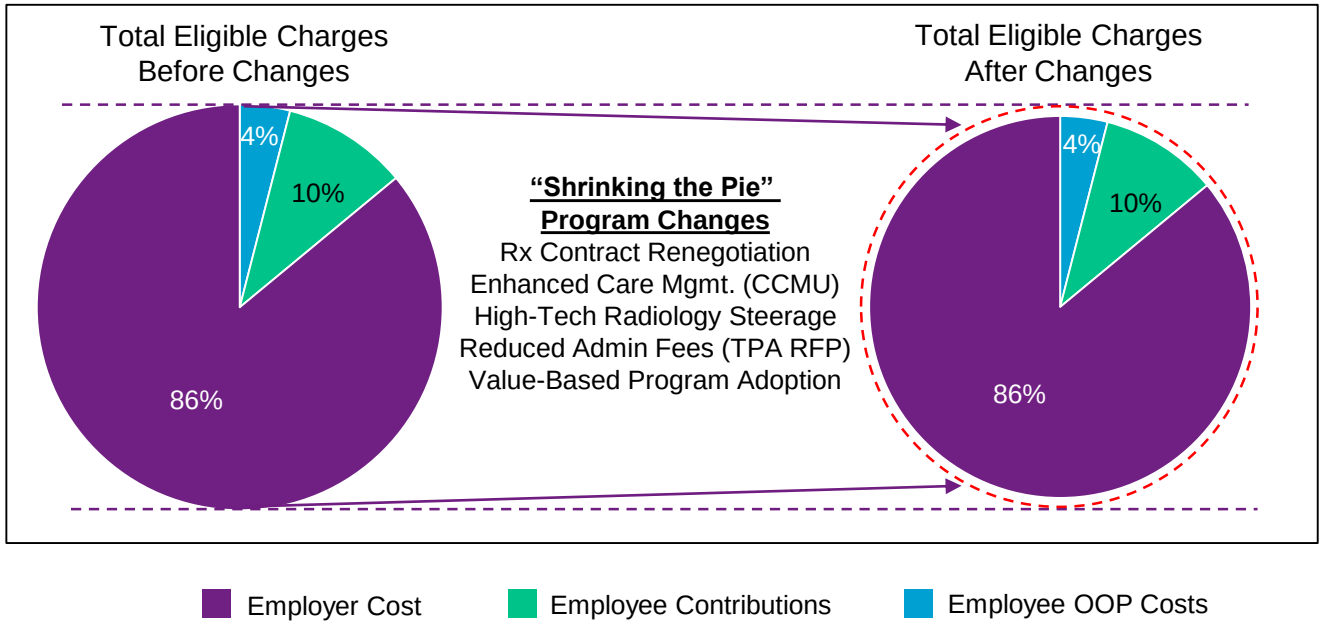
Most Recent Considerations
Site-of-Care Steerage
Centers of Excellence
Reference-Based Pricing

Ongoing/Future Considerations
Further penetration of value-based plans and networks
Plan option evaluation (HSA consideration)
Network steerage
Third party vendor health and engagement tools

[1]Reduction of medical trend, penetration into value-based care delivery space and increased enrollment in consumer and value-driven plans

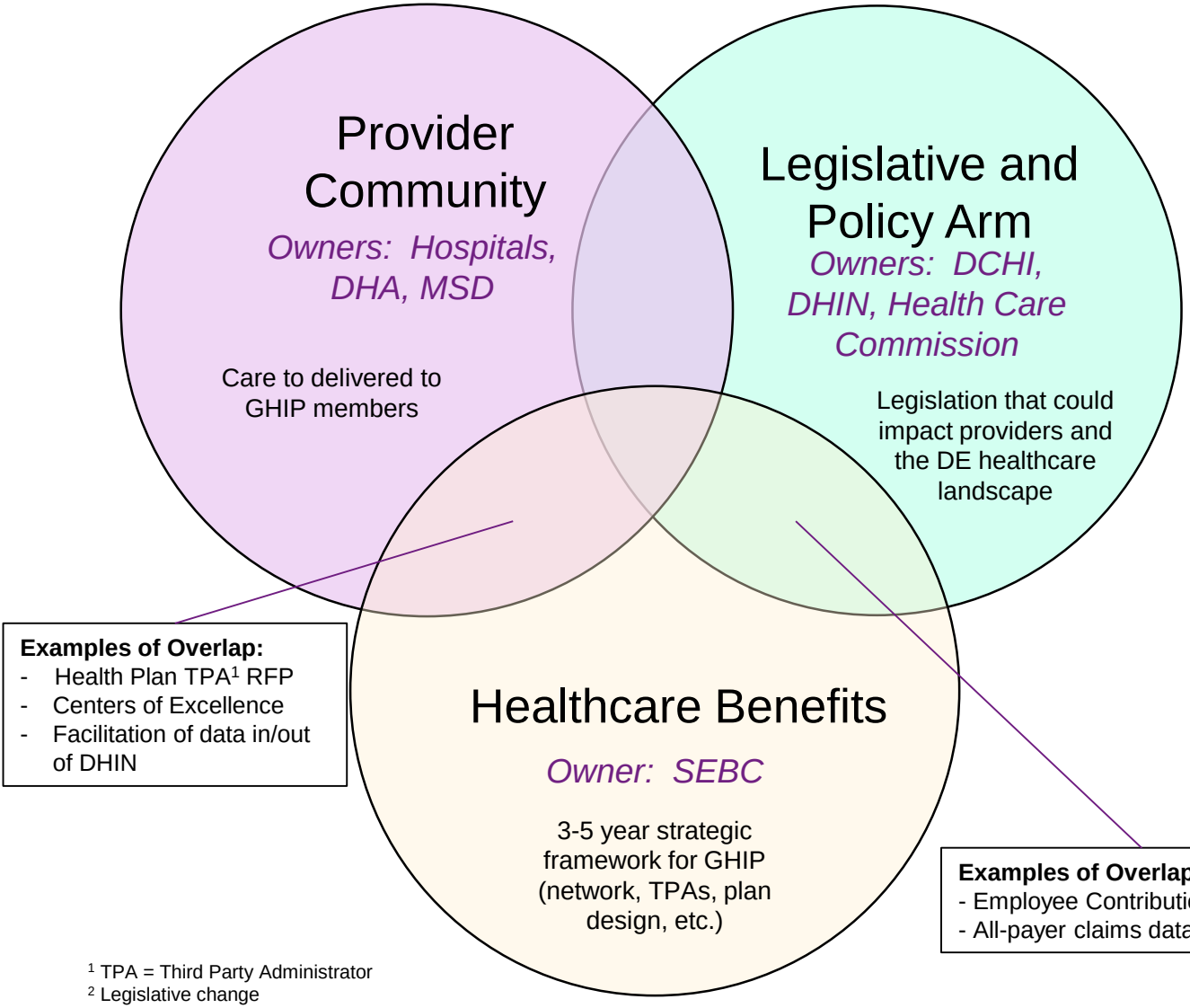
“Shrinking the pie”

- The SEBC developed a mission statement that identified several tenets, including an emphasis on providing adequate access to high quality healthcare at an **affordable cost**
- To that end, tactics implemented by the SEBC to-date have been largely focused on improving the efficiency of the GHIP program – to “shrink the pie” or take money out of the system
  - Efficiency can be achieved by shifting how and where members utilize services, changing how providers and payers are reimbursed, and/or improving the overall health of the GHIP population
  - Reduces the overall cost for the GHIP (both State and members covered under the plan) without necessarily reducing the value of the benefits provided to members
- The SEBC should continue to look for opportunities to improve program efficiency and further shrink the pie



Size of above cost charts shown as illustrative. Impact of general health care inflation not shown.

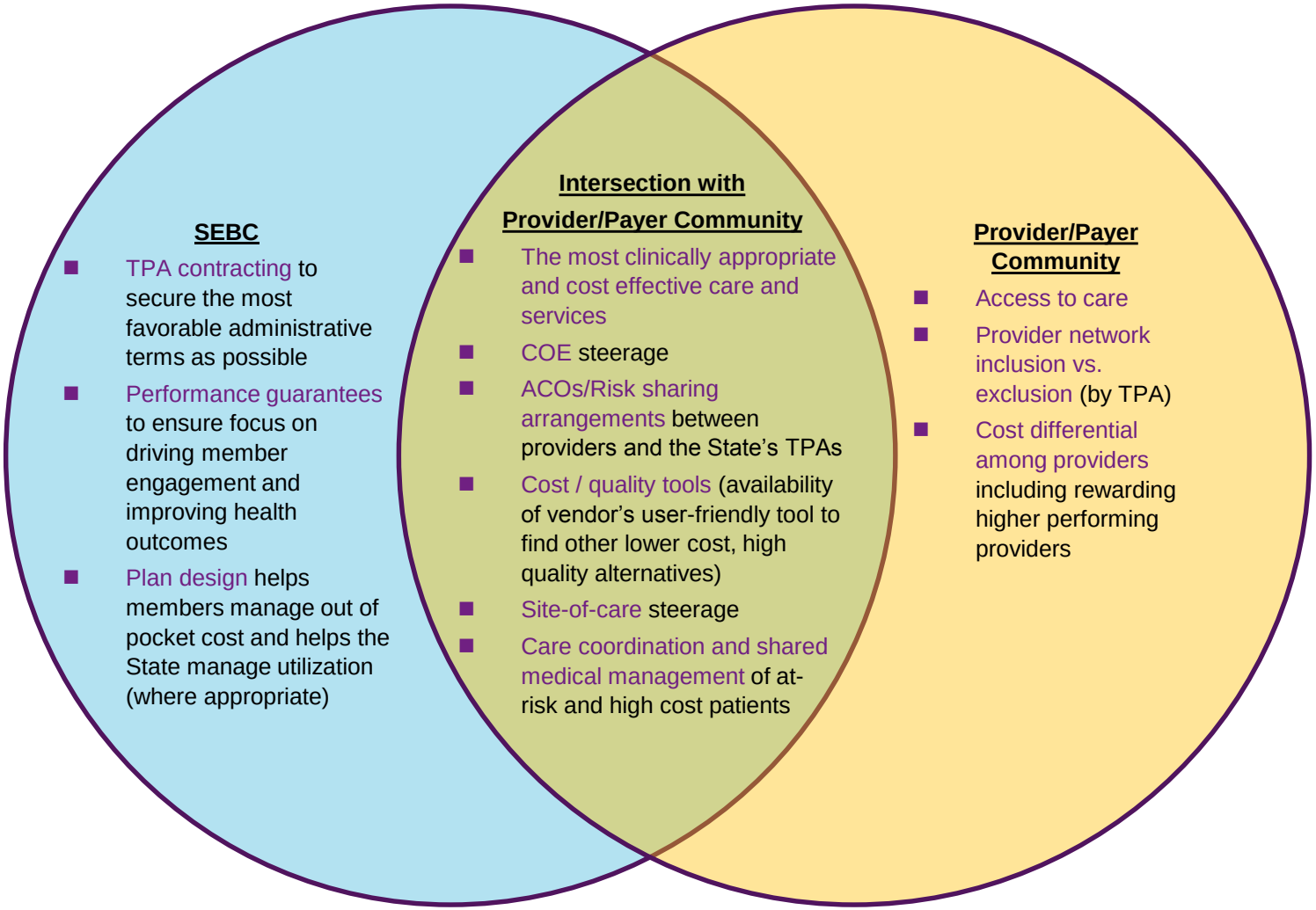
Key influencers on GHIP



- The role of the SEBC is closely aligned with managing the healthcare benefits programs offered to employees and pensioners
- Outside of the SEBC, there are many stakeholders, of which, two are identified here, that have partial overlap with the committee: the provider community and the legislative and policy arm of the State of Delaware

[1] TPA = Third Party Administrator
[2] Legislative change

Addressing cost and access with Delaware healthcare providers



Long Term Health Care Cost Projections for GHIP

GHIP funding status – current state recap

- GHIP Fund Equity balance as of 6/30/2017 is $102.7m
  - $25m surplus above Claims Liability and Minimum Reserve
  - Surplus projected to increase to $36m by the end of Fiscal Year 2018
- FY18 budget epilogue language called for the SEBC to approve changes no later than 1/1/2018 generating a minimum of $2m savings for the General Fund
- In light of current surplus, consider delaying changes until 7/1/2018 and using a portion of GHIP surplus to offset OPEB liability on a onetime basis for FY18
  - No change to State and employee premium contributions for the remainder of FY18, with a commitment to implement program initiatives for FY19
- Potential changes may include the following:
  - Site-of-care steerage – basic imaging, high tech imaging, and/or outpatient lab
  - Centers of excellence – cardiac, knee/hip and/or spinal procedures (where available)
  - Reference based pricing
    - Likely not feasible given administrative and communication challenges and potential member negative impact

GHIP long term health care cost projections

- Absent program changes or increases to premium levels, GHIP expenditures are projected to exceed premium contributions by $40 million in Fiscal Year 2019
  - Premium contributions would need to increase by 5% to cover projected expenditures
- Current GHIP surplus will be eroded if revenue growth (i.e., increases to premium contributions) does not keep pace with expected increases in health care expenditures
- The exhibits on the following pages illustrate the multi-year financial impact of implementing program changes discussed during the August 21, 2017 SEBC meeting*

Opportunity	Annual Claim Savings ($)	Annual Claim Savings General Fund ($)	Claim Savings 2H FY18 General Fund ($)
Site-of-Care Steerage	$1.3m	$0.8m	$0.5m
Centers of Excellence	$5.0m	$3.2m	$1.6m

- Premium contributions will also likely need to increase in FY19 (and beyond)
  - Illustration reflects impact of a 2% annual increase in premium contributions (State and employee/pensioner share) each year starting 7/1/2018; 2% is significantly below national average health care trend of 6%**

* Based on program designs modeled for 8/21/2017 SEBC meeting; plan provisions and services still TBD
** Source: Willis Towers Watson 2017 Best Practices in Health Care Employer Survey
Figures are rounded to nearest $0.1m. Rounding may cause some numbers to vary slightly from original document

GHIP long term health care cost projections

No Program Changes

GHIP Costs ($ millions)	FY17 Actual	FY18 Projected	FY19 Projected	FY20 Projected	FY21 Projected	FY22 Projected	FY23 Projected
GHIP Revenue							
Premium Contributions (No Change)[1]	$799.0	$810.3	$810.3	$810.3	$810.3	$810.3	$810.3
Other Revenues[2]	$81.6	$85.1	$87.3	$91.7	$96.3	$101.1	$106.2
Total Operating Revenues	**$880.6**	**$895.4**	**$897.6**	**$902.0**	**$906.6**	**$911.4**	**$916.5**
GHIP Expenses (Claims/Fees)							
Operating Expenses (No Change)[3]	$816.8	$881.5	$937.5	$984.5	$1,032.7	$1,084.3	$1,137.5
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$13.9**	**($39.9)**	**($82.5)**	**($126.1)**	**($172.9)**	**($221.0)**
Balance Forward	$38.9	$102.7	$116.6	$76.7	($5.8)	($131.9)	($304.8)
Ending Balance	$102.7	$116.6	$76.7	($5.8)	($131.9)	($304.8)	($525.8)
- Less Claims Liability[5]	*$54.0*	*$56.5*	*$60.1*	*$63.1*	*$66.2*	*$69.5*	*$72.9*
- Less Minimum Reserve[5]	*$24.0*	*$24.0*	*$25.5*	*$26.8*	*$28.1*	*$29.5*	*$30.9*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$36.1**	**($8.9)**	**($95.7)**	**($226.2)**	**($403.8)**	**($629.6)**

Note: FY17 Actual based on final June 2017 Fund Equity report and FY18 Projected based on final approved budget as of 8/26/2017 and FY18 elections as of June 2017.

[1] Includes State and employee/pensioner premium contributions and assumes no increase to premiums 7/1/2017 and beyond.

[2] Includes Rx rebates, EGWP payments, participating group fees, and other revenues.

[3] FY19 expenses based on 24-months of claims experience through June 2017, preliminary trend assumptions, year 2 ESI contract savings, and savings from initiatives adopted 7/1/2017. FY20-FY23 projected assuming 5% annual increase over FY19 (6% health care trend less 1% reduction).

[4] Claims Liability and Minimum Reserve levels shown to increase with overall GHIP expense growth for FY19-FY23.

GHIP long term health care cost projections

After Potential Changes eff. 7/1/2018

GHIP Costs ($ millions)	FY17 Actual	FY18 Projected	FY19 Projected	FY20 Projected	FY21 Projected	FY22 Projected	FY23 Projected
GHIP Revenue							
Premium Contributions (No Change)[1]	$799.0	$810.3	$810.3	$810.3	$810.3	$810.3	$810.3
Other Revenues[2]	$81.6	$85.1	$87.3	$91.7	$96.3	$101.1	$106.2
7/1 Rate Action (2019-2023 + 2% annual premium increase	-	-	*$16.2*	*$32.4*	*$48.6*	*$64.8*	*$81.0*
Total Operating Revenues	**$880.6**	**$895.4**	**$913.8**	**$934.4**	**$955.2**	**$976.2**	**$997.5**
GHIP Expenses (Claims/Fees)							
Operating Expenses (No Change)[3]	$816.8	$881.5	$937.5	$984.5	$1,032.7	$1,084.3	$1,137.5
Cumulative Savings Opportunities[4]							
- Site-of-Care Steerage	-	-	*($1.3)*	*($2.7)*	*($4.2)*	*($5.8)*	*($7.5)*
- Centers of Excellence	-	-	*($5.0)*	*($10.3)*	*($15.9)*	*($21.8)*	*($28.0)*
Adjusted Operating Expenses	**$816.8**	**$881.5**	**$931.2**	**$971.5**	**$1,012.6**	**$1,056.7**	**$1,102.0**
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$13.9**	**($17.4)**	**($37.1)**	**($57.4)**	**($80.5)**	**($104.5)**
Balance Forward	$38.9	$102.7	$116.6	$99.2	$62.1	$4.7	($75.8)
Ending Balance	$102.7	$116.6	$99.2	$62.1	$4.7	($75.8)	($180.3)
- Less Claims Liability[5]	*$54.0*	*$56.5*	*$59.7*	*$62.3*	*$64.9*	*$67.7*	*$70.6*
- Less Minimum Reserve[5]	*$24.0*	*$24.0*	*$25.4*	*$26.5*	*$27.6*	*$28.8*	*$30.0*
- Less Deposit to OPEB Trust	-	*$3.0*	-	-	-	-	-
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$33.1**	**$14.1**	**($26.7)**	**($87.8)**	**($172.3)**	**($280.9)**

Note: FY17 Actual based on final June 2017 Fund Equity report and FY18 Projected based on final approved budget as of 8/26/2017 and FY18 elections as of June 2017.

[1] Includes State and employee/pensioner premium contributions and assumes no increase to premiums 7/1/2017 and beyond.

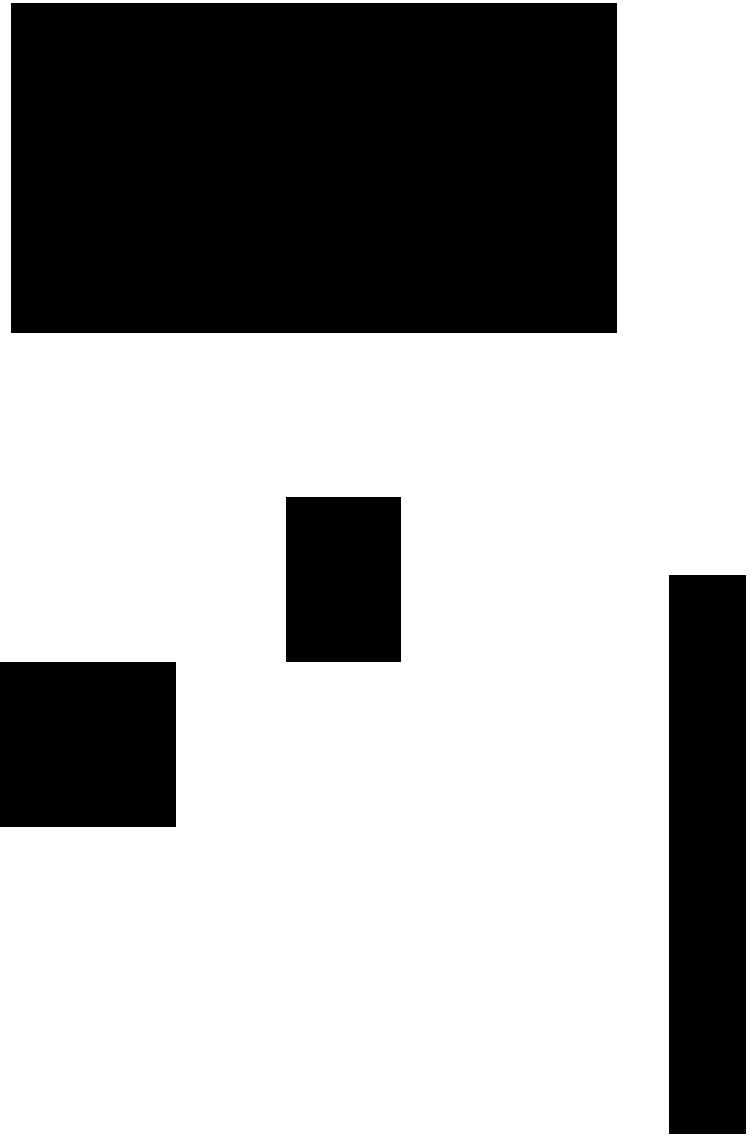
[2] Includes Rx rebates, EGWP payments, participating group fees, and other revenues.

[3] FY19 expenses based on 24-months of claims experience through June 2017, preliminary trend assumptions, year 2 ESI contract savings, and savings from initiatives adopted 7/1/2017. FY20-FY23 projected assuming 5% annual increase over FY19 (6% health care trend less 1% reduction).

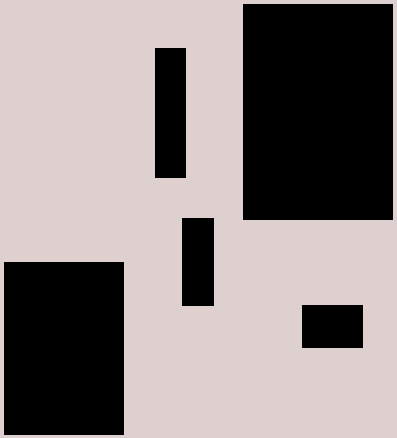
[4] Assumes savings opportunities adopted 7/1/2018, as modeled for the 8/21/2017 SEBC meeting. Savings estimates provided by Aetna and Highmark

[5] Claims Liability and Minimum Reserve levels shown to increase with overall GHIP expense growth for FY19-FY23.

FY18/FY19 Planning



Site-of-Care Steerage



Considerations for the SEBC

Site-of-care steerage

Topic Refresher:

Members pay lower out-of-pocket costs for using the most appropriate place of service for the care they need.

- Both Aetna and Highmark administer site-of-care steerage for the State today for select services

Service	Current Provision (eff. 7/1/2016)	Utilization Results through March 2017*
Urgent Care	• Urgent Care visit: $15/$20 copay (HMO/PPO) • Emergency room visit: $150 copay	• Visits to emergency rooms for urgent care treatable conditions declined by 1.4% • Utilization of urgent care facilities increased by 6.6%
High Tech Imaging	• Outpatient facility, freestanding: $0 copay • Outpatient facility, hospital-based: $35 copay	• Utilization of high tech radiology services declined by 3.1% in outpatient hospital facilities • Utilization of high tech radiology services increased by 5.6% in freestanding facilities

* Source: Truven FY 2017 3rd Quarter Utilization report. Based on most recent 12 months of incurred data (4/1/2016 – 3/31/2017) compared to prior 12 months incurred period (4/1/2015 – 3/31/2016). Copay differential implemented 7/1/2016 for the PPO and HMO plans.

Considerations for the SEBC

Revised design alternatives

- The following plan design options were modeled by Aetna and Highmark for the Comprehensive PPO and HMO plans:

Service	Current	Preliminary Design 1[1]	Design 2	Design 3	Design 4
Basic Imaging • Freestanding Facility • Hospital-based Facility	 • $20 copay • $20 copay	 • $0 copay • $35 copay	 • $10 copay • $45 copay	 • $20 copay • $55 copay	 • $25 copay • $60 copay
High Tech Imaging • Freestanding Facility • Hospital-based Facility	 • $0 copay • $35 copay	 • $0 copay • $50 copay	 • $10 copay • $60 copay	 • $20 copay • $70 copay	 • $25 copay • $75 copay
Outpatient Lab • Preferred Lab • Other Lab	 • $10 copay • $10 copay	 • $10 copay • $20 copay	 • $10 copay • $25 copay	 • $10 copay • $30 copay	 • $10 copay • $35 copay

- For both Aetna and Highmark, freestanding facilities owned by hospitals (i.e., Christiana Care Health System Imaging Centers) are treated as outpatient hospital facilities, and would not benefit from the lower copay for freestanding facilities
- If the GHIP were to implement site-of-care steerage for Basic Imaging Services through freestanding facilities, the number of imaging centers available to GHIP members in Delaware through the Aetna and Highmark respective networks would remain unchanged

[1] Preliminary design presented during 8/21 SEBC meeting

Site-of-care steerage

Estimated savings summary

Carrier	Modeled Designs	Annual Claim Savings (%)	Annual Claim Savings ($)	Annual Claim Savings General Fund ($)
Aetna	Preliminary Design 1[1]	0.35%	$0.5m	$0.3m
Highmark		0.20%	$0.8m	$0.5m
		Total Saving Opportunity – Design 1:	**$1.3m**	**$0.8m**
Aetna	Design 2	0.48%	$0.7m	$0.5m
Highmark		0.33%	$1.3m	$0.8m
		Total Savings Opportunity – Design 2:	**$2.0m**	**$1.3m**
Aetna	Design 3	0.65%	$1.0m	$0.6m
Highmark		0.58%	$2.2m	$1.4m
		Total Savings Opportunity – Design 3:	**$3.2m**	**$2.0m**
Aetna	Design 4	0.85%	$1.3m	$0.8m
Highmark		0.70%	$2.7m	$1.7m
		Total Savings Opportunity – Design 4:	**$4.0m**	**$2.5m**

- The four design options modeled above assume design changes are adopted to promote site-of-care steerage for basic imaging services, high-tech imaging services and outpatient lab services
  - Consistent with existing site-of-care steerage design, modeling assumes that these changes would only apply to the Comprehensive PPO and the HMO plans
  - CDH Gold and First State Basic plans already have member cost differential build into design (via coinsurance for most plan provisions) to incentivize utilization of lower cost providers
- Member disruption will vary based on procedure, education and specific provider

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels
Savings for active and pre-65 retiree populations only
[1] Preliminary design presented during 8/21 SEBC meeting; rounding may cause some numbers to vary slightly from original document

Aetna/Highmark site-of-care steerage

Estimated savings summary – Preliminary Design (Design 1)[1]

Type of service	Current (Aetna HMO/ Comprehensive PPO In-network)	Preliminary Proposed Design 1	Aetna HMO Annual Claim Savings[2]		Total Savings Opportunity	Highmark Comprehensive PPO (In-network design) Annual Claim Savings[2]		Total Savings Opportunity
			(%)	($)		(%)	($)	
Basic imaging services (e.g., X-rays, ultrasounds)	▪ Outpatient facility: $20 copay	▪ Outpatient facility, freestanding: $0 copay ▪ Outpatient facility, hospital-based: $35 copay	0.05%	$0.1m	**$0.5m** ($0.3m general fund)	0.10%	$0.4m	**$0.8m** ($0.5m general fund)
High tech imaging services (e.g., MRI, CT scans)	▪ Outpatient facility, freestanding: $0 copay ▪ Outpatient facility, hospital-based: $35 copay	▪ Outpatient facility, freestanding: $0 copay ▪ Outpatient facility, hospital-based: $50 copay	0.05%[3]	$0.1m		0.05%	$0.2m	
Outpatient lab services	▪ Any lab: $10 copay	▪ Preferred lab (Quest/ LabCorp): $10 copay ▪ All other labs: $20 copay	0.20%	$0.3m		0.05%	$0.2m	

Combined Aetna/Highmark Total Annual Savings Opportunity – Preliminary Design 1: $1.3m

- Savings estimates assume that these changes are applicable only to Aetna HMO plan and Highmark Comprehensive PPO plan in-network design provisions
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and hospital-based outpatient facilities to differentiate between basic imaging and high tech imaging

[1] Preliminary design presented during 8/21 SEBC meeting.
[2] Savings estimates based on assumed utilization; estimates provided on 9/6/2017. Savings for active and pre-65 retiree populations only.
[3] Aetna commented that high tech imaging services yield <0.1% claims savings. 0.05% savings assumed.

Aetna/Highmark site-of-care steerage

Estimated savings summary – Design 2

Type of service	Current (Aetna HMO/ Comprehensive PPO In-network)	Proposed Design 2	Aetna HMO Annual Claim Savings[1]		Total Savings Opportunity	Highmark Comprehensive PPO (In-network design) Annual Claim Savings[1]		Total Savings Opportunity
			(%)	($)		(%)	($)	
Basic imaging services (e.g., X-rays, ultrasounds)	▪ Outpatient facility: $20 copay	▪ Outpatient facility, freestanding: $10 copay ▪ Outpatient facility, hospital-based: $45 copay	0.15%	$0.3m	**$0.7m** ($0.5m general fund)	0.24%	$0.9m	**$1.3m** ($0.8m general fund)
High tech imaging services (e.g., MRI, CT scans)	▪ Outpatient facility, freestanding: $0 copay ▪ Outpatient facility, hospital-based: $35 copay	▪ Outpatient facility, freestanding: $10 copay ▪ Outpatient facility, hospital-based: $60 copay	0.08%[2]	$0.1m		0.03%	$0.1m	
Outpatient lab services	▪ Any lab: $10 copay	▪ Preferred lab (Quest/ LabCorp): $10 copay ▪ All other labs: $25 copay	0.25%[3]	$0.3m		0.06%[3]	$0.3m	

Combined Aetna/Highmark Total Annual Savings Opportunity – Design 2: $2.0m

- Savings estimates assume that these changes are applicable only to Aetna HMO plan and Highmark Comprehensive PPO plan in-network design provisions
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and hospital-based outpatient facilities to differentiate between basic imaging and high tech imaging

[1] Savings estimates based on assumed utilization; estimates provided on 9/6/2017. Savings for active and pre-65 retiree populations only.
[2] Aetna commented that high tech imaging services yield <0.15% claims savings. 0.08% savings assumed.
[3] Lab savings estimated from initial projection provided by Aetna and Highmark.

Aetna/Highmark site-of-care steerage

Estimated savings summary – Design 3

Type of service	Current (Aetna HMO/ Comprehensive PPO In-network)	Proposed Design 3	Aetna HMO Annual Claim Savings[1]		Total Savings Opportunity	Highmark Comprehensive PPO (In-network design) Annual Claim Savings[1]		Total Savings Opportunity
			(%)	($)		(%)	($)	
Basic imaging services (e.g., X-rays, ultrasounds)	▪ Outpatient facility: $20 copay	▪ Outpatient facility, freestanding: $20 copay ▪ Outpatient facility, hospital-based: $55 copay	0.25%	$0.4m	**$1.0m** ($0.6m general fund)	0.41%	$1.6m	**$2.2m** ($1.4m general fund)
High tech imaging services (e.g., MRI, CT scans)	▪ Outpatient facility, freestanding: $0 copay ▪ Outpatient facility, hospital-based: $35 copay	▪ Outpatient facility, freestanding: $20 copay ▪ Outpatient facility, hospital-based: $70 copay	0.10%[2]	$0.1m		0.09%	$0.4m	
Outpatient lab services	▪ Any lab: $10 copay	▪ Preferred lab (Quest/ LabCorp): $10 copay ▪ All other labs: $30 copay	0.30%[3]	$0.5m		0.08%[3]	$0.2m	

Combined Aetna/Highmark Total Annual Savings Opportunity – Design 3: $3.2m

- Savings estimates assume that these changes are applicable only to Aetna HMO plan and Highmark Comprehensive PPO plan in-network design provisions
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and hospital-based outpatient facilities to differentiate between basic imaging and high tech imaging

[1] Savings estimates based on assumed utilization; estimates provided on 9/6/2017. Savings for active and pre-65 retiree populations only.
[2] Aetna commented that high tech imaging services yield <0.20% claims savings. 0.10% savings assumed.
[3] Lab savings estimated from initial projection provided by Aetna and Highmark.

Aetna/Highmark site-of-care steerage

Estimated savings summary – Design 4

Type of service	Current (Aetna HMO/ Comprehensive PPO In-network)	Proposed Design 4	Aetna HMO Annual Claim Savings[1]		Total Savings Opportunity	Highmark Comprehensive PPO (In-network design) Annual Claim Savings[1]		Total Savings Opportunity
			(%)	($)		(%)	($)	
Basic imaging services (e.g., X-rays, ultrasounds)	▪ Outpatient facility: $20 copay	▪ Outpatient facility, freestanding: $25 copay ▪ Outpatient facility, hospital-based: $60 copay	0.30%	$0.5m	**$1.3m** ($0.8m general fund)	0.48%	$1.8m	**$2.7m** ($1.7m general fund)
High tech imaging services (e.g., MRI, CT scans)	▪ Outpatient facility, freestanding: $0 copay ▪ Outpatient facility, hospital-based: $35 copay	▪ Outpatient facility, freestanding: $25 copay ▪ Outpatient facility, hospital-based: $75 copay	0.20%	$0.3m		0.13%	$0.5m	
Outpatient lab services	▪ Any lab: $10 copay	▪ Preferred lab (Quest/ LabCorp): $10 copay ▪ All other labs: $35 copay	0.35%[2]	$0.5m		0.09%[2]	$0.4m	

Combined Aetna/Highmark Total Annual Savings Opportunity – Design 4: $4.0m

- Savings estimates assume that these changes are applicable only to Aetna HMO plan and Highmark Comprehensive PPO plan in-network design provisions
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and hospital-based outpatient facilities to differentiate between basic imaging and high tech imaging

[1] Savings estimates based on assumed utilization; estimates provided on 9/6/2017. Savings for active and pre-65 retiree populations only.
[2] Lab savings estimated from initial projection provided by Aetna and Highmark.

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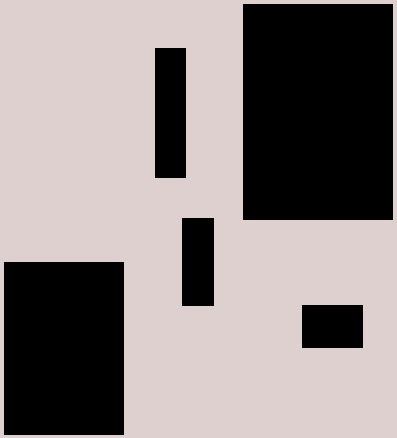

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Comparison of Carve-in and Carve-out Approaches

- While Highmark and Aetna both offer COEs for a wide variety of procedures, there exist several carve-out vendors that can administer a COE network
- Three leaders in this space include: BridgeHealth, Carrum Health and SurgeryPlus
  - BridgeHealth: Network not currently built in the DE (and surrounding) marketplace
  - Carrum Health: Network primarily located in western United States
  - SurgeryPlus: Network not currently built in the DE (and surrounding) marketplace

Comparison of Carve-in and Carve-out COE Approaches

	Medical Carriers	Carve-Out Vendors
COE Capabilities	More established in the COE marketplace than carve-out vendors and offer a wider range of procedures. Generally, COE is not available but specific procedure, but only by group of procedure categories (i.e., cardiac)	Offer more flexibility and robust concierge coordination support
COE Network	Focus on facility COE designations, but these may differ from other provider designations such as Aetna Aexcel and Highmark True Performance	Approaches to network development vary; some are facility-based and others are provider/surgeon-based
Savings and ROI	Do not typically offer bundled pricing or ROI or savings transparency	Focus on bundled pricing / case rates. Some carve-out vendors have demonstrated greater willingness to tie savings and ROI to performance guarantees
Fees	Fee often embedded within core ASO fees, or nominal PEPM fee charged for steerage to COE network	Typically charge a fee (PEPM and/or a percentage of savings associated with the bundled case rates per surgery)

- **Although carve-out niche COE vendors exist, because the network has not yet been established, the SEBC should continue to monitor the marketplace for developments and consideration of future vendor exploration**

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Considerations for the SEBC

Topic Refresher:

A Center of Excellence (COE) is a facility that has been identified as delivering high quality services and superior outcomes for specific procedures or conditions. COEs may incorporate separate contracting arrangements for a predetermined set of services (e.g., bundled payments). Plan design steerage to encourage use of COEs is optional.

- Both Aetna and Highmark designate certain facilities within their provider networks as COEs
- Neither Aetna nor Highmark's COE network can be customized to exclude higher cost providers (this is due to contractual agreements between the TPA and providers)
- Aetna and Highmark COE network comments:
  - Both vendors are unable to designate out-of-network providers/facilties as COEs
  - For Highmark, the Blue Cross Blue Shield Association guidelines do not allow for the administration of customized plan design steerage to a COE for certain procedures but not others
    - All COE procedures are bundled; Highmark's system does not allow unbundling
    - Highmark's system only provides two options for COE benefit election, "Yes" to have all applicable procedure codes included or "No" to opt out
  - Aetna cannot customize COEs to steer members only to certain procedures
    - COEs are intended to be a broader offering in each specialty area (bariatric, cardiac and orthopedic) and systems are setup at COE level, not procedure level
    - Based on Aetna's experience, plan sponsors participate in COEs targeting the best savings resulting from steering towards multiple procedures

[1] Reimbursement available for patient and one companion and applies to all COEs (bariatric, cardiac and orthopedic)

Centers of excellence

Considerations for the SEBC

- In-network prior authorization currently in place and is performed by the provider
- Vendors do not consider requiring members to personally request prior authorization as a viable approach to educating members on the availability of COEs through customer service
  - Aetna unable to require members to call customer service for prior authorization, such approach is typical for out-of-network providers
  - Highmark indicated that if providers call promptly for prior authorization there may be opportunity for the health coach team to contact the patient prior to the procedure, however:
    - Success of the outreach would depend on the member picking up the call
    - Approach may be challenging as member and surgeon most likely have agreed on the facility in advance and changes may be frustrating for the member
- Vendor recommendations, based on BOB customer experience for member steerage towards COEs:
  - Aetna and Highmark agreed on implementing a benefit differential that favors COE use
  - For plan sponsors with narrow networks in place, Aetna usually recommends aligning the COE benefit design with the narrow network design (i.e. 80% coinsurance for services delivered through COEs, 60% for in-network non-COE and 50% for out-of- network)
  - Highmark emphasized the importance of executing an effective communication strategy

[1] Reimbursement available for patient and one companion and applies to all COEs (bariatric, cardiac and orthopedic)

Centers of excellence

Available ✓
Not Available ✘

Comparison of COE-covered procedures by Aetna and Highmark

- Procedures available through Cardiac COEs

DRG #	Diagnostic Related Group (DRG)	Aetna	Highmark
215	Other heart assist system implant	✓	✘
216	Cardiac valve & other major cardiothoracic procedure w card cath w/ MCC	✓	✓
217	Cardiac valve & other major cardiothoracic procedure w card cath w/CC	✓	✘
218	Cardiac valve & other major cardiothoracic procedure w card cath w/o CC/MCC	✓	✓
219	Cardiac valve & other major cardiothoracic procedure w/o card cath w/ MCC	✓	✓
220	Cardiac valve and other major cardiothoracic procedure w/o card cath w/CC	✓	✓
221	Cardiac valve & other major cardiothoracic procedure w/o card cath w/o CC/MCC	✓	✓
222	Cardiac defibrillator implant w/ cardiac cath w/ AMI/HF/shock w/ MCC	✓	✘
223	Cardiac defibrillator implant w cardiac cath w AMI/HF/shock w/o MCC	✓	✘
224	Cardiac defibrillator implant w/ cardiac cath w/o AMI/HF/shock w/ MCC	✓	✘
225	Cardiac defibrillator implant w/ cardiac cath w/o AMI/HF/shock w/o MCC	✓	✘
226	Cardiac defibrillator implant w/o cardiac cath w/ MCC	✓	✘
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	✓	✘
228	Other cardiothoracic procedure w/ MCC	✓	✘
229	Other cardiothoracic procedure w/o MCC	✓	✘
231	Coronary bypass w/ PTCA w/ MCC	✓	✘
232	Coronary bypass w/ PTCA w/o MCC	✓	✓
233	Coronary bypass w/ cardiac cath w/ MCC	✓	✓
234	Coronary bypass w cardiac cath w/o MCC	✓	✓
235	Coronary bypass w/o cardiac cath w/ MCC	✓	✓
236	Coronary bypass w/o cardiac cath w/o MCC	✓	✓
237	Major cardiovascular procedures w/ MCC	✓	✘
238	Major cardiovascular procedures w/o MCC	✓	✘
242	Permanent cardiac pacemaker implant w/ MCC	✓	✘
243	Permanent cardiac pacemaker implant w/ CC	✓	✘
244	Permanent cardiac pacemaker implant w/o CC/MCC	✓	✘
245	AICD generator procedures	✓	✘

MCC: Major Complication or Comorbidity; CC: Complication or Comorbidity

[1] Reimbursement available for patient and one companion and applies to all COEs (bariatric, cardiac and orthopedic)

Centers of excellence

Available ✓
Not Available ✗

Comparison of COE-covered procedures by Aetna and Highmark

- Procedures available through Cardiac COEs *(continued)*

DRG #	Diagnostic Related Group (DRG)	Aetna	Highmark
246	Perc cardiovascular procedure w/ drug-eluting stent w/ MCC	✓	✓
247	Perc cardiovascular procedure w drug-eluting stent w/o MCC	✓	✓
248	Perc cardiovascular procedure w/ non-drug eluting stent w/ MCC	✓	✓
249	Perc cardiovascular procedure w non-drug-eluting stent w/o MCC	✓	✗
250	Perc cardiovascular procedure w/o coronary artery stent w/ MCC	✓	✓
251	Perc cardiovascular procedure w/o coronary artery stent w/o MCC	✓	✓
258	Cardiac pacemaker device replacement w/ MCC	✓	✗
259	Cardiac pacemaker device replacement w/o MCC	✓	✗
268	Aortic and heart assistance procedure except pulsation balloon w/ MCC	✓	✗
269	Aortic and heart assistance procedure except pulsation balloon w/o MCC	✓	✗
270	Other major cardiovascular procedures w/ MCC	✓	✗
271	Other major cardiovascular procedures w/CC	✓	✗
272	Other major cardiovascular procedures w/o CC/MCC	✓	✗
273	Percutaneous intracardiac procedures w/ MCC	✓	✗
274	Percutaneous intracardiac procedures w/o MCC	✓	✗
308	Cardiac arrhythmia & conduction disorders w/ MCC	✓	✗
309	Cardiac arrhythmia & conduction disorders w/CC	✓	✗
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	✓	✗
981	Extensive O.R. procedure unrelated to principal diagnosis	✗	✓

MCC: Major Complication or Comorbidity; CC: Complication or Comorbidity

[1] Reimbursement available for patient and one companion and applies to all COEs (bariatric, cardiac and orthopedic)

Centers of excellence

Available ✓
Not Available ✘

Comparison of COE-covered procedures by Aetna and Highmark

- Procedures available through Orthopedic and Spine COEs

DRG #	Diagnostic Related Group (DRG)	Aetna	Highmark
Orthopedic			
461	Bilateral or multi major joint procedures of lower extremity w/ MCC	✓	✘
462	Bilateral or multi major joint procedures of lower extremity w/o MCC	✓	✓
464	Wound debridement and skin graft except hand, for musculoskeletal and connective tissue disorders w/ CC	✘	✓
466	Revision of hip or knee replacement w/ MCC	✓	✘
467	Revision of hip or knee replacement w/ CC	✓	✓
468	Revision of hip or knee replacement w/o CC/ MCC	✓	✓
469	Major joint replacement w/ MCC	✓	✓
470	Major joint replacement w/o MCC	✓	✓
Spine			
28	Spinal procedure w/ MCC	✘	✓
29	Spinal procedure w/ CC or spinal neurostimulator	✘	✓
30	Spinal procedure w/o CC/MCC	✘	✓
453	Combined anterior/posterior spinal fusion w/ MCC	✓	✓
454	Combined anterior/posterior spinal fusion w/ CC	✓	✓
455	Combined anterior/posterior spinal fusion w/o CC/MCC	✓	✓
456	Spinal fusion except cervical w/ spinal curv/ infection/ malign or 9+ fusion w/ MCC	✓	✓
457	Spinal fusion except cervical w/ spinal curv/ infection/ malign or 9+ fusion w/ CC	✓	✓
458	Spinal fusion except cervical w/ spinal curv/ infection/ malign or 9+ fusion w/o CC MCC	✓	✓
459	Spinal fusion except cervical w/ MCC	✓	✓
460	Spinal fusion except cervical w/o MCC	✓	✓
471	Cervical spinal fusion w/ MCC	✓	✓
472	Cervical spinal fusion w/o CC	✓	✓
473	Cervical spinal fusion w/o MCC	✓	✓
519	Back and neck procedures, except spinal fusion w/ CC	✘	✓
520	Back and neck procedures, except spinal fusion w/o CC/MCC	✘	✓
957	Multiple significant trauma	✘	✓

MCC: Major Complication or Comorbidity; CC: Complication or Comorbidity

[1] Reimbursement available for patient and one companion and applies to all COEs (bariatric, cardiac and orthopedic)

Centers of excellence

Historical view of COE utilization for GHIP members ***(Highmark)***[1]

Type of COE	Procedure	Total number of procedures (All facility types)	Total performed at COE facilities	Total performed at In-network non-COE facilities	Total performed at out-of-network facilities
Cardiac	Cardiac Valve	33	24	9	-
	Coronary Bypass	43	39	4	-
	Procedures with Coronary Artery Stent	100	87	13	-
	Extensive O.R. Procedure Unrelated to Principal Diagnosis	1	1	-	-
Orthopedic	Major Joint Procedures	23	9	14	-
	Revision of Hip or Knee Replacement	27	10	17	-
	Major Joint Replacement	632	137	495	-
Spine	Spine Surgery	11	8	3	-
	Spinal Fusion	143	111	32	-
	Multiple Significant Trauma	1	1	-	-
	Other Spinal Procedures	6	5	1	-

- Chart above reflects 24 months of GHIP experience for all cardiac, knee/hip and spinal procedures accessible through Highmark COEs
- All cardiac, orthopedic and spine procedures were performed at in-network COE and non-COE facilities
  - 58% of procedures were performed at non-COE facilities, driven by major joint replacement
  - The majority of major joint replacements were done in an in-network non-COE facility

[1] Claims period 08/01/2015 - 07/31/2017

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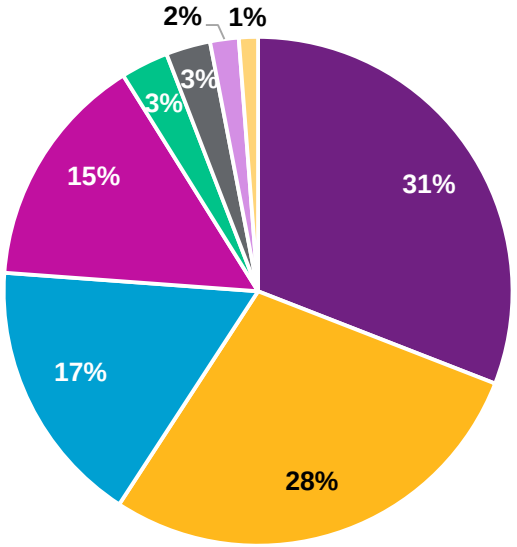
Historical view of COE utilization for GHIP members ***(Highmark)***

- 632 major joint replacements reported by Highmark from 8/1/2015 to 7/31/2017, 137 performed at COE facilities and 495 at in-network non-COE facilities
- The chart below details the procedures, categorized as major joint replacements, performed at in-network non-COE facilities (91% of total)
  - 59% (293) right or left knee joint replacements
  - 32% (158) right or left hip joint replacements



Orthopedic COE – Major Joint Replacement	
Procedures	**Total number of procedures performed at In-network non-COE facilities**
Right knee joint replacement	153
Left knee joint replacement	140
Right hip joint replacement	84
Left hip joint replacement	74
Total knee replacement	15
Other[1]	14
Percutaneous anesthetic into peripheral nerves and plexi	9
Total hip replacement	6
Total Major Joint Replacement Procedures	**495**

[1] "Other" category includes procedures performed less than three times during the 24-month period evaluated. Left hip joint, femoral surface replacement (3), left knee joint femoral surface replacement (3) therapeutic musculoskeletal exercise treatment (3); right knee joint tibial surface replacement (2), left knee joint tibial surface replacement (1), partial hip replacement (1) and right hip joint acetabular surface replacement (1)

Centers of excellence

Historical view of COE utilization for GHIP members ***(Aetna)***[1]

Type of COE	Procedure	Total number of procedures (All facility types)	Total performed at COE facilities	Total performed at In-network non-COE facilities	Total performed at out-of-network facilities
Cardiac	Interventional[2]	2	-	2	-
	Rhythm	5	5	-	-
	Surgery	1	-	1	-
Orthopedic/ Spine	Total Joint Replacement	19	8	11	-
	Spine	17	15	2	-

- Chart above reflects 24 months of GHIP experience for all cardiac, knee/hip and spinal procedures accessible through Aetna COEs
- All cardiac, orthopedic and spine procedures were performed at in-network COE and non-COE facilities
  - All cardiac/rhythm procedures and most spine procedures were delivered at COE facilities
  - The majority of total joint replacements were done in an in-network non-COE facility

[1] Claim period 07/01/2014 - 06/30/2016
[2] Catheter based treatment of structural heart diseases

Next Steps

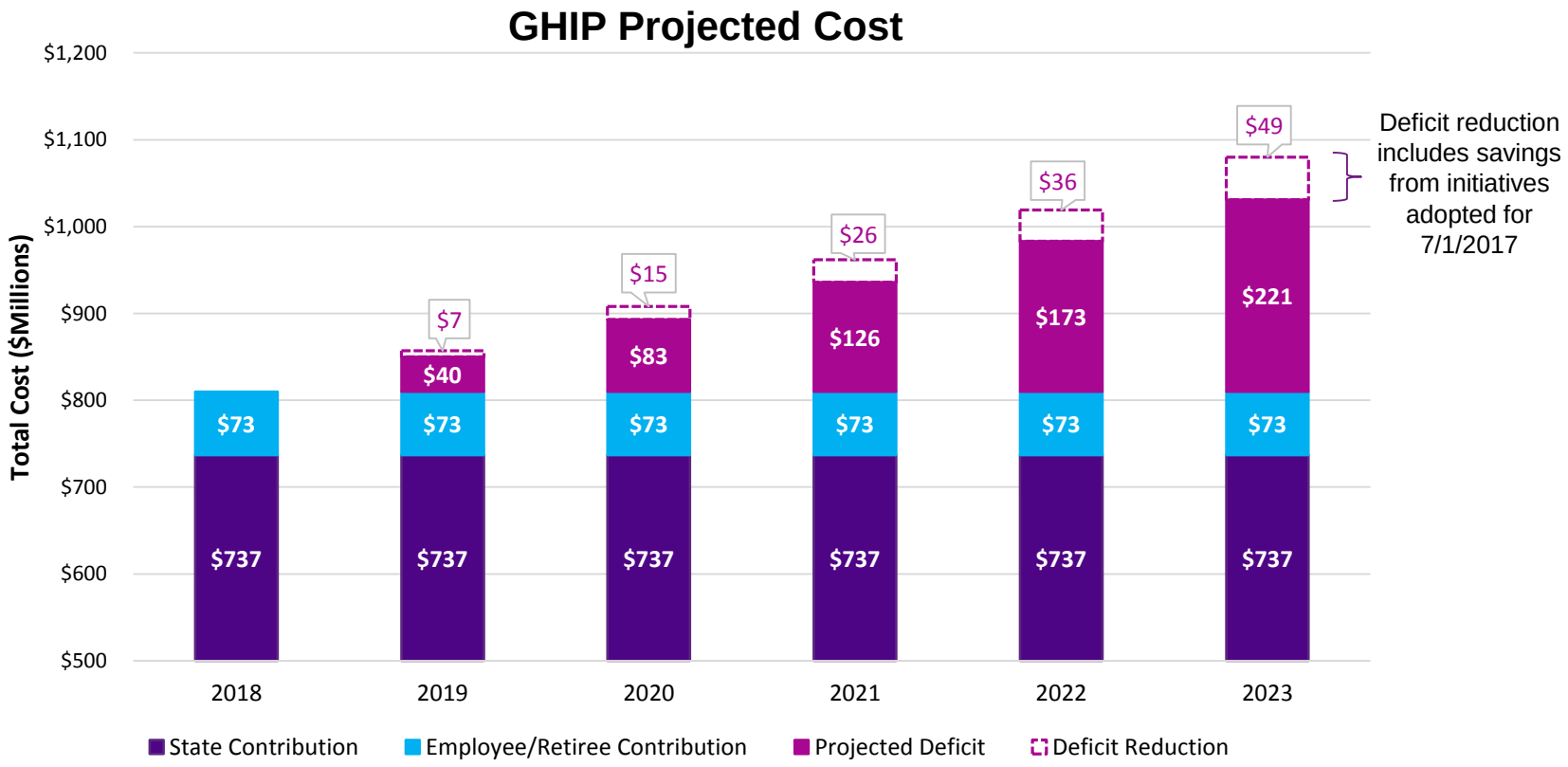
Next steps

- Items to discuss at upcoming SEBC meetings for FY18 and beyond:
  - OPEB contribution/OPEB presentation by David Craik, Pension Office Administrator
  - Site-of-care steerage
  - Centers of excellence
  - Spousal Coordination of Benefits Policy changes
  - Group Health Eligibility and Enrollment Rule changes
  - Employer-sponsored clinic follow up
  - Active enrollment
  - Health savings accounts
  - Possibility of modification to the plan year to align with calendar year (i.e., 7/1 to 1/1)
  - Cost transparency
  - High performing providers
  - Plan design changes

Appendix

Long term health care cost projections

Long term cost projections reflect claims experience through June 2017 and approved program changes adopted for 7/1/2017, including vendor value-based care models (Aetna AIM and Highmark True Performance), enhanced Highmark clinical management program (CCMU), and utilization management through U.S. Imaging. The projected GHIP deficit has been reduced by **$133 million** over 5 years compared to prior estimates.

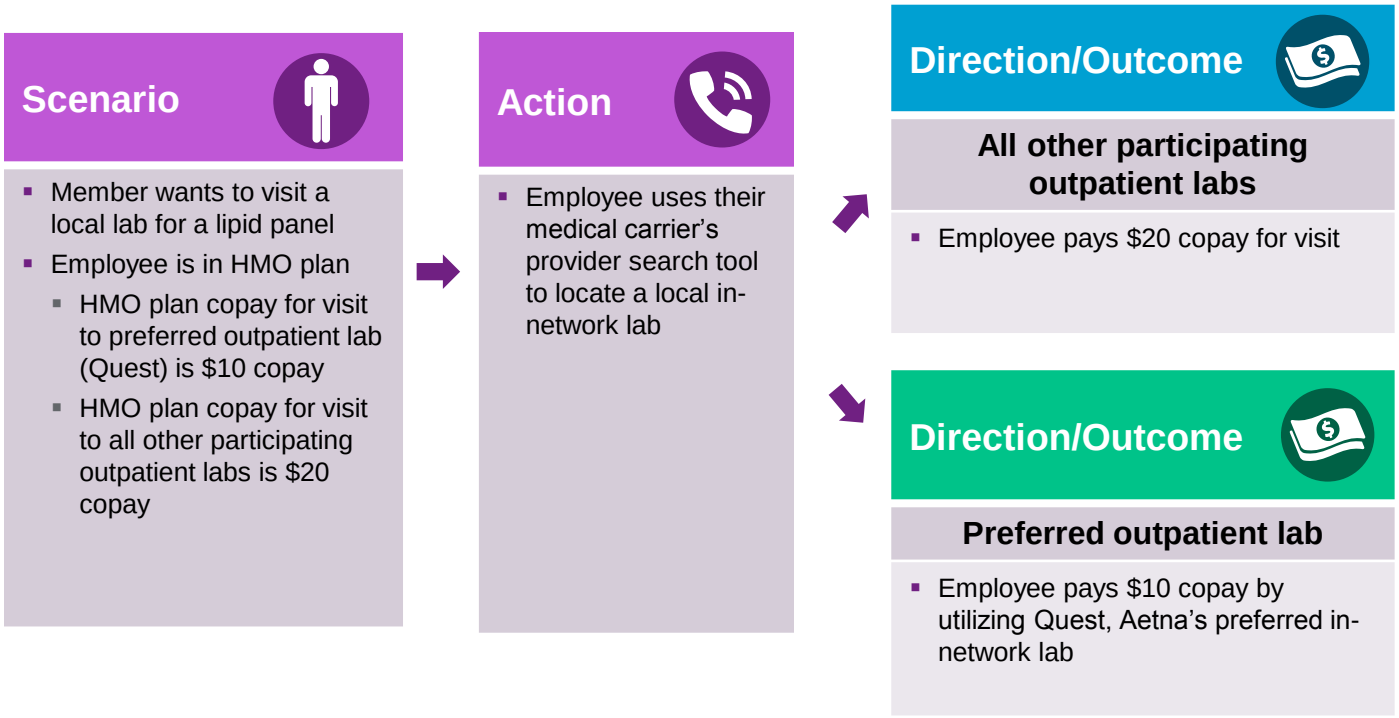


Note: FY18 budget projections assume no change to FY17 rates, and FY18 open enrollment elections as of June 2017. FY19 budget projections reflect GHIP claims experience through June 2017, reduction in EGWP direct subsidy payments effective 1/1/2018, and incremental savings from Year 3 of ESI contract. FY20 and beyond costs projected assuming 1% reduction in annual health care trend (from 6% to 5%) resulting from initiatives approved to date in FY18. Budget projections do not reflect any additional program changes.

Site-of-care steerage

Member impact – illustrative scenario *(assuming site-of-care steerage adopted)*

HMO Plan – Outpatient Lab	
Current Provision	Proposed Provision (Illustrative)
▪ $10 copay for any participating outpatient lab	▪ $10 copay for preferred outpatient lab (Quest) ▪ $20 copay for all other participating outpatient labs



Centers of excellence: medical carriers vs. carve-out vendors

Category	Medical Carriers	Carve-Out Vendors
General Overview	▪ **Pro:** Established practices, networks, and offerings ▪ **Con:** Less flexibility and innovation. Lack of consistent alignment between COE and other high-performance network strategies	▪ **Pro:** Newer entrants to market allows for more flexibility, room for innovation ▪ **Con:** Execution risk associated with less-established vendors. Variation in medical carrier willingness to partner
Conditions Covered	▪ Generally cover a wider range of conditions and procedures, including maternity, infertility and cancer	▪ Covered conditions and procedures are more limited, although some are in development
Provider Quality + Selection Criteria	▪ Most plans are focused on quality of facility with re-credentialing every 1-3 years ▪ Combination of quality, efficiency and volume evaluation, based on variety of internal criteria and public credentialing data sources - e.g. NCQA, CAQH, Joint Commission, etc.	▪ Some are more focused on provider/surgeon quality with more frequent monitoring ▪ Combination of quality, efficiency and volume evaluation, based on public credentialing data sources - e.g. NCQA, CAQH, Joint Commission, etc. ▪ Methodology and capability vary by vendor – some utilize advanced analytics, for example multi-variant risk-adjustment
Concierge / Care Coordination	▪ Generally less robust than carve-out vendors; however, support varies by carrier and condition (e.g. transplants have more in-depth support) ▪ Some after-hours coverage available, but varies by carrier	▪ More robust with concierge-centric approach including appointment scheduling, record management, travel and lodging support and surgeon to PCP coordination ▪ After-hours coverage somewhat more limited than medical carriers
Steerage Capabilities	▪ Able to support benefit differentials, although may require a buy-up fee	▪ Able to support a variety of steerage approaches including benefit differentials, cash incentives
Integration w/ Medical Carriers	▪ N/A	▪ Experience integrating with major medical carriers varies widely by vendor and TPA
Financials	▪ Often no separate fee is assessed for COE, but some medical carriers have varied fees by condition ▪ Little or no standard performance guarantees around service or ROI ▪ Typically not willing to provide warrantees	▪ Typically PEPM and/or percentage of case rate or savings assessed ▪ Willing to guarantee ROI in certain circumstances ▪ Two of three vendors are willing to provide warrantees

Aetna and Highmark COE criteria

- Aetna COE definition – facilities that have demonstrated high levels of quality and cost efficiency performing certain procedures
  - **Institutes of Quality** – Bariatric, Cardiac, Orthopedic (joint replacement and spinal surgery)
  - **Institutes of Excellence** – Transplants (organ and bone marrow), Infertility Treatment
- Highmark COE definition – facilities that deliver high-quality care and superior outcomes for high-risk, high-cost surgical procedures ("Blue Distinction Specialty Care" nationwide quality designation)
  - Specialty areas – Bariatric, Cancer (rare and complex), Cardiac, Maternity, Orthopedic – Knee & hip replacement, Orthopedic – Spinal surgery, Transplants
  - **Blue Distinction Centers (BDC)** – demonstrated quality care, treatment expertise and, overall, better patient results
  - **Blue Distinction Centers+ (BDC+)** – offer more affordable care in addition to having demonstrated quality care, treatment expertise, and, overall, better patient results

Centers of excellence

Estimated savings summary

Carrier	Annual Claim Savings (%)	Annual Claim Savings ($)	Annual Claim Savings General Fund ($)	Claim Savings 2H FY18 General Fund ($)
Aetna	0.90%	$1.4m	$0.9m	**$0.4m**
Highmark	0.93%	$3.6m	$2.3m	**$1.2m**

Total FY18 Savings Opportunity: $1.6m

- Modeling above assumes adoption of steerage to COEs for ALL applicable cardiac, knee/hip and spinal procedures
- Savings attributable to COE benefit design driven by plan design changes (increased member cost sharing at non-COE facilities) and improvements in quality associated with increased COE use
  - Roughly $0.9m of the $1.6m savings in FY18 attributable to plan design cost shifting, assuming that a portion of members use non-COE facilities despite the higher cost sharing—remaining savings ($0.7m) related to improved quality standards of COE-designation
  - Benefit differential will drive additional utilization of COE facilities, improving quality of care and reducing GHIP long term costs
- Member disruption will vary based on procedure, education and specific provider

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels
List of COE facilities (within 100 miles of DE) for Aetna and Highmark are located within the appendix on pages 37 and 38, respectively
Savings for active and pre-65 retiree populations only

Aetna centers of excellence

Estimated savings

	Current	Proposed	Annual Claim Savings[1]	
			(%)	($)
Cardiac ▪ Coronary artery bypass graft surgery ▪ Heart valve surgery ▪ Cardiac medical intervention (i.e. Angioplasty) ▪ Rhythm (pacemakers and ICD) **Orthopedic/spine** ▪ Knee replacements ▪ Hip replacements ▪ Spine surgery	▪ Inpatient Hospital, all facilities (in-network) **CDH Gold** Covered at 90%, after $1,500 deductible **HMO** Covered at 100%, after $100 per day copay for the first two days per confinement, and 100% no copay thereafter	▪ Inpatient Hospital, **COE Facility** (in-network) **CDH Gold** Covered at 90% after $1,500 deductible **HMO** Covered at 100%, after $100 per day copay for the first two days per confinement, and 100% no copay thereafter ▪ Inpatient Hospital, **Non-COE Facility** (in-network) **CDH Gold** Covered at **75%** after $1,500 deductible **HMO** Covered at **75%** with no deductible and no copay	0.90%	$1.4m ($0.4m general fund second half FY18)

- Above designs create a meaningful spread between COE and non-COE facilities
- Services rendered at non-COE facilities were modeled at 75% coinsurance after the applicable deductible
  - Member coinsurance would accumulate towards total out-of-pocket maximum for cardiac and orthopedic procedures listed above, at COE and non-COE facilities

1. Estimates provided by Aetna on 7/26/2017. Savings for active and pre-65 retiree populations only.

Highmark centers of excellence

Estimated savings

	Current	Proposed	Annual Claim Savings[1] (%)	Annual Claim Savings[1] ($)
Cardiac ▪ Coronary artery bypass graft surgery ▪ Heart valve surgery ▪ Angioplasty **Orthopedic** ▪ Knee replacements ▪ Hip replacements **Spine** ▪ Discectomy ▪ Fusion ▪ Decompression	▪ Inpatient Hospital, all facilities (in-network) **Comprehensive PPO** Covered at 100%, after $100 per day copay for the first two days per confinement, no deductible **First State** Covered at 90% for unlimited days, after $500 deductible[2] **POS** Covered at 90%, no deductible	▪ Inpatient Hospital, **COE Facility** (in-network) **Comprehensive PPO** Covered at 100%, after $100 per day copay for the first two days per confinement, no deductible **First State** Covered at 90% for unlimited days, after $500 deductible[2] **POS** Covered at 90%, no deductible ▪ Inpatient Hospital, **Non-COE Facility** (in-network) **Comprehensive PPO** Covered at **75%**, after $100 per day copay for the first two days per confinement, no deductible **First State** Covered at **75%** for unlimited days, after $500 deductible[2] **POS** Covered at **75%**, no deductible	0.93%	$3.6m ($1.2m general fund second half FY18)

- Above designs create an meaningful spread between COE and non-COE facilities
- Services rendered at non-BDC facilities were estimated at 75% coinsurance after the applicable deductible
- The above includes estimated savings resulting from lower readmissions, higher quality of care, etc.

1. Estimates provided by Highmark on 8/7/2017. Savings for active and pre-65 retiree populations only.
2. Deductible shown for individual, family deductible $1,000
3. 75% coverage for Bariatric surgery performed at non-BDC facility does not accumulate towards the total out-of-pocket maximum as it is not an essential health benefit under the ACA

Centers of excellence

Aetna – criteria evaluated for COE designation (All)

- All facilities must meet the following criteria to be eligible for individual or combined Cardiac, Orthopedic or Spine COE designations

Cardiac and Orthopedic (knee/hip) and Spine[1]

- Credentialed by Aetna, participate in Aetna's provider network and be accredited by appropriate external entities
- Have available the following clinical services for consultation and daily primary care:
  - Anesthesiology
  - Cardiology
  - Pulmonology
  - Radiology
  - Infectious disease
  - Behavioral health
  - Intensive care unit
  - Specialized equipment
  - Nutrition counseling/education
  - Pharmacist
- Meet quality and clinical outcomes and reporting:
  - Within the most recent 12 calendar months of data available, the facility's mortality and complication rates for selected conditions and procedures must be less than or equal to the minimums established.
  - Have a quality improvement program, with initiatives focused on continuously measuring and improving orthopedic care to include an automated data collection system and/or personnel in place.
  - Perform patient satisfaction surveys and responsive improvement activities.

[1] Facilities must meet all requirements for knee and hip replacement to be designated for either, while spine surgery designation may be a stand-alone designation

Centers of excellence

Aetna – criteria evaluated for Cardiac COE designation

- Facilities must meet the following criteria to be eligible for Cardiac COE designation

Cardiac

Facilities must have one or more of the following designations:

- Cardiac medical interventions
- Cardiac rhythm disorders
- Cardiac surgery

Facility requirements:

- 12-month procedure volumes must meet or exceed the following metrics:
  - 200 percutaneous coronary interventions
  - 200 open heart surgery cases
  - 125 cardiac resynchronization therapy device implantation procedures
- Credentialed by Aetna, participate in Aetna's provider network and be accredited by appropriate external entities
- Provide required on-site availability (7 days a week) to cardiologists, cardiovascular surgeons and electrophysiologists
- At least 50% of physicians must be board certified in specialties treating primarily cardiac disease
- Anesthesiologists, pathologists and radiologists treating patients for cardiac services must participate in Aetna's provider network for all products unless inadequate access exists.
- Have emergency response teams available 24/7, including the following:
  - An advanced cardiac life support (ACLS) certified physician
  - Policies and specialists available to perform urgent and emergency primary percutaneous coronary interventions when applying for Cardiac Medical Intervention IOQ designation
  - Policies for and specialists available to perform cardiac surgery when applying for Cardiac Surgery IOQ designation
  - The emergency department must have on-call response teams available to perform urgent and emergency invasive cardiovascular procedures
- Provide daily rounds to all cardiac patients in intensive care unit by intensivists, pulmonologists, cardiologists, cardiovascular surgeons or internists
- Provide a clinical pharmacist daily medical review for cardiac patients in the intensive care unit (ICU).
- Provide adult cardiac services including emergency care required by the IOQ designation, including:
  - Emergency care
  - Medical care of cardiac conditions (for example, heart failure, acute myocardial infarction)
  - Percutaneous coronary interventions
  - Open heart surgery
  - Care of heart rhythm disorders and placement of implantable cardiac resynchronization devices for the most recent 12 consecutive calendar months
- Make referrals to structured smoking-cessation and cardiac rehabilitation programs
- Meet additional quality and clinical outcomes and reporting:
  - Report cardiovascular case information to external registries for procedures established by the American College of Cardiology and the Society of Thoracic Surgeons, or equivalent state or regional reporting and quality improvement registry

IOQ: Institutes of Quality; Aetna COE definition

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Aetna – criteria evaluated for Orthopedic/Spine COE designation

- Facilities must meet all requirements for knee and hip replacement to be designated for either, while spine surgery designation may be a stand-alone designation

Orthopedic (knee/hip)	Spine
Facility requirements for knee and hip replacement: ▪ Perform at least 200 knee replacement and 100 hip replacement surgeries in the most recent 12 calendar months ▪ Have one physician (in each of the categories) that performed at least 50 knee replacement surgeries and 50 hip replacement surgeries in the most recent 12 calendar months ▪ Have a total joint replacement program established for at least one year ▪ Have anesthesiologists, pathologists and radiologists delivering orthopedic services participate in Aetna network for all products unless inadequate access exists	Facility requirements for spine surgery: ▪ Perform at least 100 spine surgeries in the most recent 12 calendar months ▪ Have one physician that performs at least 50 spine surgeries in the most recent 12 calendar months ▪ Have been established for at least one year ▪ Have an acceptable percentage of the facility's orthopedic surgeons or neurosurgeons credentialed by Aetna and participating in Aetna's network ▪ Have anesthesiologists, pathologists and radiologists treating patients for spine surgery credentialed by Aetna and participate in Aetna's provider network for all products unless inadequate access exists

Facility requirements for knee/hip replacement and spine surgery:

- Must be accredited by one of the following:
  - The Joint Commission (JJC)
  - Healthcare Facilities Accreditation Program (HFAP)
  - American Osteopathic Association
  - National Integrated Accreditation for Healthcare Organizations (NIAHO)
  - Det Norske Veritas (DNV) Healthcare
- Have available emergency services, including rapid response team and intensive care unit (ICU)
- Must provide on-site availability (seven days a week) of specialist physicians participating in Aetna's network for all products offered in the market
- Have at least 50% of orthopedic surgeons or neuro surgeons providing services board certified
- Make available psychiatry and physical therapy/occupational therapy for consultation and daily primary care
- Meet additional quality and clinical outcomes and reporting:
  - Report orthopedic case information to external registries for orthopedic procedures established by National Surgical Quality Improvement Program (NSQIP), Premier Clinical Advisor, or equivalent state or regional reporting and quality improvement registry
  - Provide pre-operative patient education materials

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Highmark – criteria evaluated for COE designation (All)

Cardiac, Orthopedic and Spine

Facilities must meet all components to be eligible for COE designation. Evaluation components applicable to **all** COEs:

Quality: General facility structure metrics, process and outcome metrics

- Each facility must have National accreditation from at least one of the following:
  - The Joint Commission (TJC) (without provision or condition) in the Hospital Accreditation Program
  - Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Information Association (AOIA) as an acute care hospital
  - National Integrated Accreditation Program (NIAHO℠)—Acute Care of DNV GL Healthcare
  - Center for Improvement in Healthcare Quality (CIHQ) in the Hospital Accreditation Program
- Must be a comprehensive acute care facility with access to all of the following services on site:
  - Intensive care unit
  - Emergency Room and Emergency Services with plans or systems for onsite emergency admission of post-operative patients with 24/7 availability of onsite medical response teams
  - 24/7 availability of in-house emergency physician coverage
  - Diagnostic radiology, including MRI and CT
  - 24/7 inpatient pharmacy services (may include alternative night-time access when pharmacy is closed)
  - Blood bank or 24/7 access to blood bank services
  - 24/7 availability of Clinical Laboratory Improvement Amendments (CLIA) accredited laboratory services

Access (Business):

- Facility Participation: All facilities are required to participate in the local BCBS Plan's BlueCard Preferred Provider Organization (PPO) Network
- Physician Specialists Participation: All physician specialists (identified in the Provider Survey as those who perform the Cardiac Care, Knee and Hip Replacement or Spine Surgery procedures at that facility) are required to participate in the local BCBS Plan's BlueCard PPO Network
- Blue Brands Criteria: Facility meets BCBSA criteria for avoiding conflicts with BCBSA logos and trademarks
- Local BCBS Plan Criteria (if applicable): An individual Blue Plan, at its own independent discretion, may establish and apply local business requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers Program, for facilities located within its Service Area

Cost of Care[1]: Designed to address market and consumer demand for cost savings and affordable healthcare. Facilities must meet all components listed below to be eligible for COE designation

- Facility must have a minimum of 5 episodes of cost data for at least 2 clinical categories for cardiac and ortho, and at least 3 clinical categories for spine
- Composite Facility Cost Index is different for cardiac, orthopedic and spine COEs *(See respective charts)*

[1] *Cost of Care selection criteria is only applicable to facilities pursuing the Blue Distinction Centers+ (BDC+) designation*

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Highmark – criteria evaluated for Cardiac COE designation

Cardiac

Facilities must meet all components to be eligible for Cardiac COE designation

Quality: General facility structure metrics, cardiac specific process and outcome metrics

- Participate and report to the National Cardiovascular Data Registry (NCDR) CathPCI Registry all adult Percutaneous Coronary Intervention (PCI) procedures performed at the facility from July 1, 2013 through June 30, 2014
- Have the CathPCI Registry® 2014 Q2 Institutional Outcomes Report (including 4 consecutive quarters of data, which have passed all CathPCI Registry® data quality report checks)
- All cardiothoracic surgeons with cardiac surgical privileges at the facility participate in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database and submit data on all coronary artery bypass graft (CABG) surgeries and valve surgeries performed at the facility from July 1, 2013 through June 30, 2014
- For Percutaneous Coronary Intervention (PCI) Volume for Outcome Reliability, facility reports a minimum sample size of 100 or greater
- Provide calculated Upper and Lower Confidence Limit (LCL) for NCDR CathPCI Executive Summary Measures and meet required standards
- Have composite ratings of 2 stars[1] for each of the following:
  - Overall STS Isolated CABG
  - Overall STS Isolated Aortic Valve Replacement (AVR)
  - Overall STS CABG + AVR Combined
- Meet the following Hospital Compare Measures
  - Acute Myocardial Infarction (AMI) 30 day risk adjusted mortality rate is reported as “better than or no different than the national rate”
  - AMI 30 day risk adjusted readmission rate is reported as “better than or no different than the national rate

Access (Business): Same access criteria applicable to cardiac, orthopedic and spinal COEs

Cost of Care[2]: Designed to address market and consumer demand for cost savings and affordable healthcare. Facilities must meet all components listed below to be eligible for cardiac COE designation

- Facility must have a minimum of 5 episodes of cost data for at least 2 clinical categories
- Composite Facility Cost Index must be below 1.400

[1] NOTE: Facilities with more than 1 STS Participant must meet this Cardiac Care Selection Criteria **for each participant.**

[2] *Cost of Care selection criteria is only applicable to facilities pursuing the Blue Distinction Centers+ (BDC+) designation*

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Highmark – criteria evaluated for Orthopedic COE designation

Orthopedic

Facilities must meet all components to be eligible for Orthopedic COE designation

Quality: General facility structure metrics, orthopedic specific process and outcome metrics

The following criteria must be met for **eligibility** consideration:

- The total facility case volume, which includes both primary and revision total hip arthroplasty (THA) and/or total knee arthroplasty (TKA), is greater than zero for the requested timeframe
- Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) is reported as "better than" or "no different than" the U.S. National Rate and Blue National Rate[1]
- Analytic volume for 1) complication outcomes and 2) volume of readmission outcomes is at least 25 primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Blue Claims data (each)
- Hospital-level 30-day, all-cause risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) is reported as "better than" or "no different than" the U.S. National Rate and Blue National Rate[1]

The following criteria is requested for **informational** purposes:

- Functional Assessments – Percentage of knee or hip replacement patients that have undergone both pre-and post-operative functional assessment at least 6 months after surgery

Access (Business): Same access criteria applicable to cardiac, orthopedic and spinal COEs

Cost of Care[2]: Designed to address market and consumer demand for cost savings and affordable healthcare. Facilities must meet all components listed below to be eligible for Orthopedic (knee/hip) COE designation

- Facility must have a minimum of 5 episodes of cost data for at least 2 clinical categories
- Composite Facility Cost Index must be below 1.200

[1] *Must meet requirement based on the* U.S National Rate and Blue National Rate separately

[2] *Cost of Care selection criteria is only applicable to facilities pursuing the Blue Distinction Centers+ (BDC+) designation*

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Highmark – criteria evaluated for Spine COE designation

Spine

Facilities must meet all components to be eligible for Spine COE designation

Quality: General facility structure metrics, spine specific process and outcome metrics

- Analytic volume for outcome measurement is at least 30 spondylolisthesis patients who had a 1 or 2 level primary posterior lumbar fusion +/- decompression
- 1 or 2 level primary posterior lumbar fusion +/- decompression for spondylolisthesis:
  - Reoperation within 30 days. 90% lower confidence limit is at or below 3.2
  - Unplanned readmission within 30 days. 90% lower confidence limit is at or below 6.8
  - Venous thromboembolism within 30 days. 90% lower confidence limit is at or below 1.28
  - Surgical site infection within 30 days. 90% lower confidence limit is at or below 5.4
- Analytic volume for outcome measurement is at least 30 patients who had a single level primary anterior cervical fusion
- Single level primary anterior cervical fusion:
  - Reoperation within 30 days. 90% lower confidence limit is at or below 1.6
  - Unplanned readmission within 30 days. 90% lower confidence limit is at or below 4.0
  - Venous thromboembolism within 30 days. 90% lower confidence limit is at or below 0.67
  - Surgical site infection within 30 days. 90% lower confidence limit is at or below 0.87
- Facility has at least 2 spine surgeons actively performing spine surgeries
- Facility commits to examine spine surgeon procedure volume with consideration for reviewing evidence linking volume and outcomes and establishing a surgeon level case volume minimum requirement

Access (Business): Same access criteria applicable to cardiac, orthopedic and spinal COEs

Cost of Care[1]: Designed to address market and consumer demand for cost savings and affordable healthcare. Facilities must meet all components listed below to be eligible for Orthopedic (knee/hip) COE designation

- Facility must have a minimum of 5 episodes of cost data for at least 3 clinical categories
- Composite Facility Cost Index must be below 1.500

[1] *Cost of Care selection criteria is only applicable to facilities pursuing the Blue Distinction Centers+ (BDC+) designation*

Aetna COEs in Delaware and nearby states[1]

	Within Delaware	Within nearby states (up to 100 mile radius)
Cardiac	None in Delaware	**Maryland** Baltimore-area facilities – 5 Other Maryland facilities – 1 ▪ Including: Peninsula Regional Medical Center – Salisbury, MD **New Jersey** Northern-area facilities – 1 Other New Jersey facilities – 1 **Pennsylvania** Philadelphia/Southern NJ-area facilities – 1 Other Pennsylvania facilities – 5 **Washington, D.C.** D.C. and surrounding areas – 2
Orthopedic / Spine	**Christiana Care –** Wilmington, DE	**Maryland** Baltimore-area facilities – 9 Other Maryland facilities – 0 **New Jersey** Northern-area facilities – 0 Other New Jersey facilities – 0 **Pennsylvania** Philadelphia/Southern NJ-area facilities – 8 Other Pennsylvania facilities – 7 **Washington, D.C.** D.C. and surrounding areas – 4

1. Facilities that are designated as COEs for multiple clinical areas (i.e., cardiac and orthopedic/spine) are counted in each applicable clinical area above.

Highmark COEs in Delaware and nearby states[1]

	Within Delaware	Within nearby states (up to 100 mile radius)
Cardiac	**Bayhealth Hospital** – Dover DE **Beebe Medical Center** – Lewes, DE **Christiana Care –** Newark, DE	**Maryland** Baltimore-area facilities – 1 Other Maryland facilities – 1 • Peninsula Regional Medical Center – Salisbury, MD **Pennsylvania** Philadelphia-area facilities – 7 Other PA facilities – 15 **Washington, D.C.** D.C. and surrounding area – 3
Orthopedic	None in Delaware	**Maryland** Baltimore-area facilities – 11 Other Maryland facilities – 7 • Including: Peninsula Regional Medical Center – Salisbury, MD **Pennsylvania** Philadelphia-area facilities – 13 (including 2 in Southern NJ) Other PA facilities – 17 **New Jersey** Other NJ facilities – 2 **Washington, D.C.** D.C. and surrounding area – 6
Spine	**Beebe Medical Center** – Lewes, DE **Christiana Care –** Newark, DE	**Maryland** Baltimore-area facilities – 8 Other Maryland facilities – 4 • Including: Peninsula Regional Medical Center – Salisbury, MD **Pennsylvania** Philadelphia-area facilities – 9 (including 1 in Southern NJ) Other PA facilities – 10 **Washington, D.C.** D.C. and surrounding area – 4

1. Facilities that are designated as COEs for multiple clinical areas (i.e., cardiac and orthopedic/spine) are counted in each applicable clinical area above.

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Member impact – illustrative scenario *(assuming COE differential adopted)*

PPO Plan – Knee Replacement Surgery	
Current Provision	Revised Provision for additional COEs (Illustrative)
▪ $100 per-day confinement copay (up to 2 days)	▪ $100 per-day confinement copay for COE-designated facility ▪ $100 per-day confinement plus 25% coinsurance for non-COE-designated facility

Scenario

- Member is covered by the Comprehensive PPO plan in EE Only coverage
- Member needs knee replacement surgery
- Primary care doctor recommends an orthopedic surgeon to perform the knee replacement
- Referral provided by primary care doctor is to a non-COE facility
- Example assumes $10,000 cost for surgery

Action

- Member calls health plan customer service to confirm whether surgeon and facility are in-network
- Member can also use their medical carrier's provider search tool to identify facilities within COE network
- Health plan customer service educates member on COE network benefits (both cost and quality)

Direction

Non COE Facility

- Member gets surgery at non-COE facility

Outcome[1]

Non COE Facility

- Member pays $200 copay plus $2,500 in coinsurance ($2,700 total)

Direction

COE Facility

- Member gets surgery at COE facility

Outcome[1]

COE Facility

- Member only pays $200 copay
- Because COE is used, additional benefits (to the member and the GHIP) include:
  - ✓ Surgery and post-operative care may be delivered more efficiently
  - ✓ Lower risk of complications and readmissions
  - ✓ Lower cost over time without sacrificing quality of care

1. Cost shown for illustrative purposes only and may vary based on provider and diagnosis.